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ABSTRACT

Given the ambiguities and serious consequences of the Human Immunodeficiency Virus (HIV), health professionals must not over simplify HIV transmission. An alarming paradox underlies HIV infection: a preventable disease rooted in human intimacy is reaching pandemic proportions. Well-publicized instances in which persons with AIDS have been shunned attest to concerns regarding HIV transmission. Recent surveys show that significant percentages of respondents believe that AIDS can be passed through casual contact. Although this may be due to some people's lack of authoritative information on AIDS and HIV, research on illness suggests that people tend to group contagious diseases like colds, chicken pox, and AIDS under one category; thus they apply a generic concept to any disease that falls into that category. Although no case of AIDS spread by casual contact has been reported, scientists have not declared such a happenstance as utterly impossible, only as highly improbable. The history, too, of the disease hampers clear thought. Since many people initially associated AIDS with specific populations, those with the disease have been stigmatized. Therefore, efforts to reduce irrational fears and the stigma surrounding AIDS should address concerns about contracting AIDS as well, and also should confront individual prejudices. Contains 14 references. (RJM)

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An Essay on AIDS Education: The Mythology of Casual Contact

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An Essay on AIDS Education: The Mythology of Casual Contact

Abstract

It can be reasonably stated that the generation of the late twentieth century has been drastically altered and terrified by the current AIDS pandemic. Although AIDS has become a worldwide tragedy, it has also provided the opportunity for health educators to demonstrate skills and expertise. The pandemic has led to the most exhaustive education efforts ever mustered against any single health entity. Although the available evidence argues strongly against casual-contact HIV transmission, many still behave as if HIV is as transmittable as the common cold. This essay attempts to analyze why education alone has failed to convince people that AIDS is not transmitted through casual contact and suggests strategies for improvement.

An Essay on AIDS Education: The Mythology of Casual Contact

"How many health educators does it take to change a light bulb?
One, but the light bulb must really want to change."

- Anonymous

History is full of examples in which breakthroughs for public good are borne out of tragedy; behind such dark clouds there is often a silver lining. The tragic circumstances that define the global problem of AIDS (acquired immunodeficiency syndrome) has given rise to opportunities never before afforded to health education. The severity of the epidemic, the essential role of education together with public demand for action, has offered the opportunity for a proactive response in the global fight against AIDS and for strengthening comprehensive health education. One of the striking aspects of the efforts to educate people about how HIV is and is not spread is the difficulty of convincing people that HIV is not spread through casual contact. Human Immunodeficiency Virus (HIV) infection squarely confronts higher education in that it is largely a health problem of young adults. Most individuals diagnosed with AIDS are in their mid-20's to mid-40's who became HIV infected in late adolescence and young adulthood. Ironically, the health problems of young adults do not occur as clinical problems in textbook isolation, but rather as complex struggles in a socio-cultural and economic context.

Although the available evidence argues strongly against the transmission of HIV through shared household effects (Friedland et. al., 1990; Gershon et. al., 1990), several reports exist concerning the consequences of direct oral contact (Salahuddin, Groopman, et al.,1984; Piazza, Chirianni, et al., 1991). Findings on the prevalence of HIV-1 in saliva (Fox, 1991; Goto, et al., 1991) conflict with reports both of greater frequency in the asymptomatic period and of no differences at different disease stages (Barr, et al., 1992). Given these ambiguities and the serious consequences of HIV-1 infection, we must be cautious of over-simplifying the nature of HIV transmission. Underlying HIV infection there exists an alarming paradox: A disease deeply rooted in human intimacy, clearly transmitted by identifiable sources, preventable through modifying human behavior yet nonetheless a disease we are failing to prevent.

Concerns regarding HIV transmission are attested to by the many well-publicized instances in which persons with AIDS have been shunned or children infected with HIV who have been barred from school (Conrad, 1986). Recent data from the National Health Interview Survey revealed that a substantial percentage of respondents harbored suspicions that HIV could be passed through casual contact. Twenty-four percent of the respondents believed that it was somewhat or very possible for a person to catch AIDS from eating in a restaurant where the cook had HIV, and 20% believed that it was possible to get AIDS by using public toilets. Only 18% said it was definitely not possible to get AIDS by sharing plates, forks, or glasses with someone with AIDS, and only 17% believed it was not possible to get AIDS by being coughed or sneezed on by someone with AIDS (Dawson, 1990). Together, these findings seem remarkable in light of the intense education efforts mounted to inform people about AIDS and HIV.

Although such results, to some extent, may reflect some people's lack of authoritative information on AIDS and HIV, research on cognition and lay illness representations suggests reasons why people may find accepting the actual facts about HIV transmission difficult. First, convincing people that something does not exist or cannot happen is not an easy accomplishment. No evidence to date indicates that anyone has contracted HIV through casual contact. However, the fact that it has not happened yet does not logically rule out the possibility that it could happen. Thus no one can say with absolute certainty that cases of HIV transmission through casual contact will not occur in the future. Research experts are careful to couch their conclusions in such terms as "highly unlikely" or "virtual impossibility." However, such scientific hedging does not rule out the possibility and may serve to exacerbate peoples fears.

Another important factor is how people form their cognitions regarding diseases, particularly contagious diseases. It has been demonstrated that people tend to interpret symptoms and other illness information through the use of cognitive prototypes that embody their understanding of different diseases (Bishop, 1991). Also, people cognitively organize disease information into categories according to features such as whether the disease is contagious or life threatening, and appear to view certain diseases as prototypical of a particular category. For example, in one study (Bishop, 1991) subjects defined contagious disease as a disease that is passed from one person to

another, usually by casual contact, and saw diseases like a cold, the flu, or chicken pox as prototypical contagious diseases. Therefore, individuals might apply a generic concept of contagious disease to any disease that falls into that category. Since 77% of the subjects named AIDS as a contagious disease and rated it as a fairly typical contagious disease, it may well be the case that people are misapplying their generic concept of a contagious disease to AIDS. This suggests that convincing people that HIV is not transmitted through casual contact requires overcoming their tendencies to identify contagious diseases with casual contact and regarding AIDS as a typical contagious disease.

Another critical factor in dispelling misinformation of HIV transmission lies in the history of the epidemic itself. AIDS was first diagnosed among male homosexuals, and in the U.S. and Europe, gay men and IV drug users make up the majority of persons with AIDS. Both of these groups have long been stigmatized, and the association of AIDS with homosexuality and drug usage has led to stigmatizing those afflicted with the disease as well (Herek & Glunt, 1988). Studies of attitudes and negative feelings about persons with AIDS have found strong associations between these attitudes and negative feelings about persons with AIDS (Pryor, Reeder, Vinacco, & Kott, 1989). The enigma of AIDS is the fact that it spread primarily among homosexual and bisexual males and intravenous drug users in the U.S. and Europe but became largely a heterosexual infection in Africa. Studies confirm that the HIV virus mutates within different human host cells in different parts of the world. And while the heterosexual community has demonstrated recurrent compassion for an AIDS-stricken gay population, it is unlikely to feel the same sense of desperate necessity that gays do over AIDS mortality. Playwright Larry Kramer, founder of Gay Men's Health Crisis believes that "AIDS is just one of many things. If I were a straight married man, I'd be worried about the quality of education in the schools. That's one reason why it's so hard to get support on AIDS. It' 'Leave me alone, I want to take care of my little garden.'" (Gorman, 1992).

What can be done to change these attitudes? Study after study confirms that information is not the problem; behavior is. Human behavior often defies scientific prediction and understanding. Research on health behaviors has shown that the practice of one health behavior is often only weakly related to the practice of others (Kirscht, 1983). Some health behaviors require that a

person actively engage in positive activities, whereas others require the avoidance of harmful ones. Thus, although a person may initiate good habits such as exercising and eating right, that same person may have difficulty in practicing safe sex. Dealing with these contradictory behaviors is likely to require concerted efforts that include both changing individual attitudes and the implementation of enlightened public policy. With respect to individual attitudes, efforts directed toward reducing irrational fears and stigma surrounding AIDS should address concerns about contracting AIDS and confronting individual prejudices. In addition, public policies that guarantee anonymity of HIV test results and prohibit discrimination against persons with AIDS can help to encourage more rational attitudes toward AIDS and those who live with it.

Today's challenges now extend beyond education for prevention. There are students with HIV infection on our campuses who require not only medical assistance but psychological and social services as well. In so doing, we must begin to prepare clinicians, faculty, and student development personnel to provide comprehensive care. This should include mandatory health education courses for primary prevention, early identification testing, and clinical follow-up services for students who discover they are infected. Many gaps still remain in our understanding of the dynamics of HIV transmission. At the state and local level the highest priorities should be to understand the precise populations at risk for HIV infection and to apply this information in directing and monitoring specific prevention-oriented health education programs.

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